

UNIVERSAL HEALTH REALTY INCOME TRUST

Form 10-K

March 09, 2010

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

x ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE
SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2009

OR

“ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE
SECURITIES EXCHANGE ACT OF 1934

For the transition period from to .

Commission File No. 1-9321

UNIVERSAL HEALTH REALTY INCOME TRUST

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(Exact name of registrant as specified in its charter)

Maryland
(State or other jurisdiction of

23-6858580
(I.R.S. Employer

incorporation or organization)

Identification Number)

Universal Corporate Center

367 South Gulph Road

19406-0958

P.O. Box 61558

(Zip Code)

King of Prussia, Pennsylvania
(Address of principal executive offices)

Registrant's telephone number, including area code: (610) 265-0688

Securities registered pursuant to Section 12(b) of the Act:

Title of each Class	Name of each exchange on which registered
Shares of beneficial interest, \$.01 par value	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act.

Yes No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Exchange Act.

Yes No

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Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days.

Yes No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files).

Yes No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K.

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See the definitions of large accelerated filer, accelerated filer and smaller reporting company in Rule 12b-2 of the Exchange Act (check one):

Large accelerated filer

Accelerated filer

Non-accelerated filer
(Do not check if a smaller
reporting company)

Smaller reporting company

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act) Yes No

Aggregate market value of voting shares and non-voting shares held by non-affiliates as of June 30, 2009: \$369,501,931. Number of shares of beneficial interest outstanding of registrant as of January 31, 2010: 12,089,560

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's definitive proxy statement for our 2010 Annual Meeting of Shareholders, which will be filed with the Securities and Exchange Commission within 120 days after December 31, 2009 (incorporated by reference under Part III).

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2009 FORM 10-K ANNUAL REPORT

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This Annual Report on Form 10-K is for the year ended December 31, 2009. This Annual Report modifies and supersedes documents filed prior to this Annual Report. Information that we file with the SEC in the future will automatically update and supersede information contained in this Annual Report. In this Annual Report, we, us, our and the Trust refer to Universal Health Realty Income Trust. In this Annual Report, the term revenues does not include the revenues of the unconsolidated limited liability companies (LLCs) in which we have various non-controlling equity interests ranging from 33% to 99%. We currently account for our share of the income/loss from these investments by the equity method (see Note 8 to the Consolidated Financial Statements included herein).

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PART I

ITEM 1. Business

General

We are a real estate investment trust (REIT) which commenced operations in 1986. We invest in health care and human service related facilities including acute care hospitals, behavioral healthcare facilities, rehabilitation hospitals, sub-acute facilities, surgery centers, childcare centers and medical office buildings (MOBs). As of December 31, 2009 we have fifty-one real estate investments or commitments located in fifteen states in the United States consisting of: (i) seven hospital facilities including three acute care, one behavioral healthcare, one rehabilitation and two sub-acute; (ii) forty MOBs (including thirty-one owned by various LLCs, two of which are currently under construction), and; (iii) four preschool and childcare centers.

Available Information

We have our principal executive offices at Universal Corporate Center, 367 South Gulph Road, King of Prussia, PA 19406. Our telephone number is (610) 265-0688. Our website is located at <http://www.uhrit.com>. Copies of the annual, quarterly and current reports we file with the SEC, and any amendments to those reports, are available free of charge on our website. Additionally, we have adopted governance guidelines, a Code of Business Conduct and Ethics applicable to all of our officers and directors, a Code of Ethics for Senior Officers and charters for each of the Audit Committee, Compensation Committee and Nominating and Corporate Governance Committee of the Board of Trustees. These documents are also available free of charge on our website. Copies of such reports and charters are available in print to any shareholder who makes a request. Such requests should be made to our Secretary at our King of Prussia, PA corporate headquarters. We intend to satisfy the disclosure requirement under Item 10 of Form 8-K relating to amendments to or waivers of any provision of our Code of Ethics for Senior Officers by promptly posting this information on our website. The information posted on our website is not incorporated into this Annual Report.

In accordance with Section 303A.12(a) of The New York Stock Exchange Listed Company Manual, we submitted our CEO's Certification to the New York Stock Exchange in 2009. Additionally, contained in Exhibits 31.1 and 31.2 of this Annual Report are our CEO's and CFO's certifications regarding the quality of our public disclosure under Section 302 of the Sarbanes-Oxley Act of 2002.

Overview of Facilities

As of December 31, 2009, we have investments or commitments in fifty-one facilities, including two new MOBs currently under construction, located in fifteen states and consisting of the following:

Facility Name	Location	Type of Facility	Ownership	Guarantor
Southwest Healthcare System, Inland Valley Campus(A)	Wildomar, CA	Acute Care	100%	Universal Health Services, Inc.
McAllen Medical Center(A)	McAllen, TX	Acute Care	100%	Universal Health Services, Inc.
Wellington Regional Medical Center(A)	W. Palm Beach, FL	Acute Care	100%	Universal Health Services, Inc.

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The Bridgeway(A)	N.Little Rock, AR	Behavioral Health	100%	Universal Health Services, Inc.
Kindred Hospital Chicago Central(B)	Chicago, IL	Sub-Acute Care	100%	Kindred Healthcare, Inc.
Kindred Hospital Corpus Christi(B,N)	Corpus Christi, TX	Sub-Acute Care	100%	Kindred Healthcare, Inc.
HealthSouth Deaconess Rehabilitation Hospital(E)	Evansville, IN	Rehabilitation	100%	HealthSouth Corporation
Family Doctor s Medical Office Bldg.(B)	Shreveport, LA	MOB	100%	Christus Health Northern Louisiana
Kelsey-Seybold Clinic at Kings Crossing(B)	Kingwood, TX	MOB	100%	St. Lukes Episcopal Health Sys.
Professional Bldgs. at Kings Crossing(B)	Kingwood, TX	MOB	100%	
Chesterbrook Academy(B)	Audubon, PA	Preschool & Childcare	100%	Nobel Learning Comm. & Subs.
Chesterbrook Academy(B)	New Britain, PA	Preschool & Childcare	100%	Nobel Learning Comm. & Subs.
Chesterbrook Academy(B)	Newtown, PA	Preschool & Childcare	100%	Nobel Learning Comm. & Subs.
Chesterbrook Academy(B)	Uwchlan, PA	Preschool & Childcare	100%	Nobel Learning Comm. & Subs.
Southern Crescent Center I(B,M)	Riverdale, GA	MOB	100%	
Southern Crescent Center, II(B,M)	Riverdale, GA	MOB	100%	

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Facility Name	Location	Type of Facility	Ownership	Guarantor
Desert Samaritan Hospital MOBs(C)	Mesa, AZ	MOB	76%	
Suburban Medical Plaza II(C)	Louisville, KY	MOB	33%	
Desert Valley Medical Center(C,G)	Phoenix, AZ	MOB	90%	
Thunderbird Paseo Medical Plaza I & II(C)	Glendale, AZ	MOB	75%	
Cypresswood Professional Center(B)	Spring, TX	MOB	100%	
Papago Medical Park(C)	Phoenix, AZ	MOB	89%	
Edwards Medical Plaza(C,G)	Phoenix, AZ	MOB	90%	
Desert Springs Medical Plaza(D)	Las Vegas, NV	MOB	99%	
Orthopaedic Specialists of Nevada Bldg.(B)	Las Vegas, NV	MOB	100%	
Santa Fe Professional Plaza(C,G)	Scottsdale, AZ	MOB	90%	
Sheffield Medical Building(B)	Atlanta, GA	MOB	100%	
Centinela Medical Building Complex(C,G)	Inglewood, CA	MOB	90%	
Summerlin Hospital MOB(D,H)	Las Vegas, NV	MOB	95%	
Summerlin Hospital MOB II(F)	Las Vegas, NV	MOB	98%	
Medical Center of Western Connecticut(B)	Danbury, CT	MOB	100%	
Mid Coast Hospital MOB(C)	Brunswick, ME	MOB	74%	
Deer Valley Medical Office II(C)	Phoenix, AZ	MOB	90%	
Rosenberg Children s Medical Plaza(C)	Phoenix, AZ	MOB	85%	
700 Shadow Lane & Goldring MOBs(D)	Las Vegas, NV	MOB	98%	
St. Mary s Professional Office Building(C)	Reno, NV	MOB	75%	
Apache Junction Medical Plaza(C)	Apache Junction, AZ	MOB	85%	
Spring Valley Medical Office Building(D)	Las Vegas, NV	MOB	95%	
Spring Valley Hospital Medical Office Building II(D)	Las Vegas, NV	MOB	95%	
Sierra San Antonio Medical Plaza(C)	Fontana, CA	MOB	95%	
Phoenix Children s East Valley Care Center(C)	Phoenix, AZ	MOB	95%	
Centennial Hills Medical Office Building I(D)	Las Vegas, NV	MOB	95%	
Canyon Springs Medical Plaza(C)	Gilbert, AZ	MOB	95%	
Palmdale Medical Plaza(F,I)	Palmdale, CA	MOB	95%	
Cobre Valley Medical Plaza(C)	Globe, AZ	MOB	95%	
Deer Valley Medical Office Building III(C,K)	Phoenix, AZ	MOB	95%	
Summerlin Hospital Medical Office Building III(F,J)	Las Vegas, NV	MOB	95%	
Vista Medical Terrace & The Sparks Medical Building(D,L)	Sparks, NV	MOB	95%	
Auburn Medical Office Building II(D,O)	Auburn, WA	MOB	95%	
Texoma Medical Plaza(P)	Denison, TX	MOB	95%	
BRB Medical Office Building(Q)	Kingwood, TX	MOB	95%	

(A) Real estate assets owned by us and leased to subsidiaries of Universal Health Services, Inc. (UHS).

(B) Real estate assets owned by us and leased to an unaffiliated third-party or parties.

(C) Real estate assets owned by a limited liability company (LLC) in which we have a non-controlling ownership interest as indicated above.

(D) Real estate assets owned by a LLC in which we have a non-controlling interest as indicated above and include tenants who are unaffiliated third-parties or subsidiaries of UHS.

(E) The lessee on the HealthSouth Deaconess Rehabilitation Hospital (Deaconess) is HealthSouth/Deaconess L.L.C., a joint venture between HealthSouth Properties Corporation and Deaconess Hospital, Inc. The lease with Deaconess was renewed during 2008 and is scheduled to expire on May 31, 2014.

(F) Real estate assets owned by a LLC in which we have a non-controlling ownership interest as indicated above. Tenants of this medical office building include subsidiaries of UHS. As a result of our related party relationship with UHS and a master lease agreement between UHS and this property, this LLC is considered to be a variable interest entity. Consequently, we consolidate the results of operations of this LLC in our consolidated financial statements.

(G) The membership interests of this entity are held by a master LLC in which we hold a 90% non-controlling ownership interest.

(H) The membership interests of this entity are held by a master LLC in which we hold a 95% non-controlling ownership interest.

(I) This MOB was completed and opened during the third quarter of 2008.

(J) This MOB was completed and opened during the first quarter of 2009.

(K) This MOB was completed and opened during the second quarter of 2009.

(L) This MOB was acquired by the LLC from a subsidiary of UHS during the third quarter of 2008.

(M) A property impairment charge was recorded on this MOB during 2008, as discussed herein.

(N) This sub-acute hospital was acquired by us during the first quarter of 2008.

(O) This MOB, was completed and opened during the third quarter of 2009.

(P) This MOB which is under construction and may include tenants which are subsidiaries of UHS, is scheduled to be completed and opened during the first quarter of 2010.

(Q) This MOB which is under construction is scheduled to be completed and opened during the third quarter of 2010.

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2010 Acquisition

During March of 2010, we invested \$5.2 million for a 95% non-controlling ownership interest in a LLC that purchased the North Valley Medical Plaza located in Phoenix, Arizona.

Other Information

Included in our portfolio at December 31, 2009 are seven hospital facilities with an aggregate investment of \$142.0 million. The leases with respect to these hospital facilities comprised approximately 61% of our revenue in 2009 and approximately 65%, of our revenues in each of 2008 and 2007. As of December 31, 2009, these leases have fixed terms with an average of 3.9 years remaining and include renewal options ranging from two to five, five-year terms. The remaining lease terms for each hospital facility, which vary by hospital, are included herein in *Item 2. Properties*.

We believe a facility's earnings before interest, taxes, depreciation, amortization and lease rental expense (EBITDAR) and a facility's EBITDAR divided by the sum of minimum rent plus additional rent payable to us (Coverage Ratio), which are non-GAAP financial measures, are helpful to us and our investors as a measure of the operating performance of a hospital facility. EBITDAR, which is used as an indicator of a facility's estimated cash flow generated from operations (before rent expense, capital additions and debt service), is used by us in evaluating a facility's financial viability and its ability to pay rent. For the hospital facilities owned by us at the end of each respective year, the combined weighted average Coverage Ratio was approximately 6.7 (ranging from 2.9 to 10.4) during 2009, 6.1 (ranging from 2.5 to 8.7) during 2008 and 4.6 (ranging from 3.3 to 7.0) during 2007. The Coverage Ratio for individual facilities varies. See *Relationship with Universal Health Services, Inc.* below for Coverage Ratio information related to the four hospital facilities leased to subsidiaries of UHS.

Pursuant to the terms of our leases for our hospital facilities and the preschool and childcare centers, each lessee, including subsidiaries of UHS, is responsible for building operations, maintenance, renovations and property insurance. We, or the LLCs in which we have invested, are responsible for the building operations, maintenance and renovations of the MOBs, however, a portion, or in some cases all, of the expenses associated with the MOBs are passed on directly to the tenants. Cash reserves have been established to fund required building maintenance and renovations at the multi-tenant MOBs. Lessees are required to maintain all risk, replacement cost and commercial property insurance policies on the leased properties and we, or the LLC in which we have invested, are also named insureds on these policies. In addition, we, UHS or the LLCs in which we have invested, maintain property insurance on all properties. For additional information on the terms of our leases, see *Relationship with Universal Health Services, Inc.*

See our consolidated financial statements and accompanying notes to the consolidated financial statements included in this Annual Report for our total assets, liabilities, debt, revenues, income and other operating information.

Relationship with Universal Health Services, Inc. (UHS)

Leases: We commenced operations in 1986 by purchasing properties of certain subsidiaries from UHS and immediately leasing the properties back to the respective subsidiaries. Most of the leases were entered into at the time we commenced operations and provided for initial terms of 13 to 15 years with up to six additional 5-year renewal terms. The current base rentals and lease and rental terms for each facility are provided below. The base rents are paid monthly and each lease also provides for additional or bonus rents which are computed and paid on a quarterly

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basis based upon a computation that compares current quarter revenue to a corresponding quarter in the base year. The leases with subsidiaries of UHS are unconditionally guaranteed by UHS and are cross-defaulted with one another.

The combined revenues generated from the leases on the UHS hospital facilities accounted for approximately 52% of our total revenue for the five years ended December 31, 2009 (approximately 51%, 55%

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and 57% for the years ended December 31, 2009, 2008 and 2007, respectively). Including 100% of the revenues generated at the unconsolidated LLCs in which we have various non-controlling equity interests ranging from 33% to 99%, the leases on the UHS hospital facilities accounted for approximately 23% of the combined consolidated and unconsolidated revenue for the five years ended December 31, 2009 (approximately 20%, 21% and 24%, for the years ended December 31, 2009, 2008 and 2007, respectively). In addition, eleven MOBs (plus one additional MOB currently under construction) owned by LLCs in which we hold various non-controlling equity interests, include or will include tenants which are subsidiaries of UHS.

Pursuant to the Master Lease Document by and among us and certain subsidiaries of UHS, dated December 24, 1986 (the *Master Lease*), which governs the leases of all hospital properties with subsidiaries of UHS, UHS has the option to renew the leases at the lease terms described below by providing notice to us at least 90 days prior to the termination of the then current term. In addition, UHS has rights of first refusal to: (i) purchase the respective leased facilities during and for 180 days after the lease terms at the same price, terms and conditions of any third-party offer, or; (ii) renew the lease on the respective leased facility at the end of, and for 180 days after, the lease term at the same terms and conditions pursuant to any third-party offer. UHS also has the right to purchase the respective leased facilities at the end of the lease terms or any renewal terms at the appraised fair market value. In addition, during 2006, as part of the overall asset exchange and substitution proposal relating to Chalmette Medical Center (*Chalmette*), as discussed below, as well as the early five year lease renewals on Southwest Healthcare System-Inland Valley Campus (*Inland Valley*), Wellington Regional Medical Center (*Wellington*), McAllen Medical Center (*McAllen*) and The Bridgeway (*Bridgeway*), we agreed to amend the Master Lease to include a change of control provision. The change of control provision grants UHS the right, upon one month's notice should a change of control of the Trust occur, to purchase any or all of the four leased hospital properties at their appraised fair market value.

During the third quarter of 2005, Chalmette, a 138-bed acute care hospital located in Chalmette, Louisiana, was severely damaged and closed as a result of Hurricane Katrina. At that time, the majority of the real estate assets of Chalmette were leased from us by a subsidiary of UHS and, in accordance with the terms of the lease, and as part of an overall evaluation of the leases between subsidiaries of UHS and us, UHS offered substitution properties rather than exercise its right to rebuild the facility or offer cash for Chalmette. Independent appraisals were obtained by us and UHS which indicated that the pre-hurricane fair market value of the leased facility was \$24.0 million. During the third quarter of 2006, we completed the asset exchange and substitution pursuant to the Asset Exchange and Substitution Agreement (*Agreement*) with UHS whereby we agreed to terminate the lease between us and Chalmette and to transfer the real property assets and all rights attendant thereto (including insurance proceeds) of Chalmette to UHS in exchange and substitution for newly constructed real property assets owned by UHS (*Capital Additions*) at Wellington, Bridgeway and Inland Valley, in satisfaction of the obligations under the Chalmette lease. The Capital Additions consist of properties which were recently constructed on, or adjacent to, facilities already owned by us as well as a recently constructed Capital Addition at Inland Valley which was completed and opened during the third quarter of 2007. Included in our net income during 2007 was a gain of \$1.7 million related to this Agreement.

The table below details the renewal options and terms for each of the four UHS hospital facilities:

Hospital Name	Type of Facility	Annual Minimum Rent	End of Lease Term	Renewal Term (years)
McAllen Medical Center	Acute Care	\$ 5,485,000	December, 2011	20(a)
Wellington Regional Medical Center	Acute Care	\$ 3,030,000	December, 2011	20(b)
Southwest Healthcare System, Inland Valley Campus	Acute Care	\$ 2,648,000	December, 2011	20(b)
The Bridgeway	Behavioral Health	\$ 930,000	December, 2014	10(c)

(a) UHS has four 5-year renewal options at existing lease rates (through 2031).

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- (b) UHS has two 5-year renewal options at existing lease rates (through 2021) and two 5-year renewal options at fair market value lease rates (2022 through 2031).
- (c) UHS has two 5-year renewal options at fair market value lease rates (2015 through 2024).

Advisory Agreement: UHS of Delaware, Inc. (the Advisor), a wholly-owned subsidiary of UHS, serves as Advisor to us under an Advisory Agreement (the Advisory Agreement) dated December 24, 1986. Pursuant to the Advisory Agreement, the Advisor is obligated to present an investment program to us, to use its best efforts to obtain investments suitable for such program (although it is not obligated to present any particular investment opportunity to us), to provide administrative services to us and to conduct our day-to-day affairs. All transactions between us and UHS must be approved by the Independent Trustees. In performing its services under the Advisory Agreement, the Advisor may utilize independent professional services, including accounting, legal, tax and other services, for which the Advisor is reimbursed directly by us. The Advisory Agreement may be terminated for any reason upon sixty days written notice by us or the Advisor. The Advisory Agreement expires on December 31 of each year; however, it is renewable by us, subject to a determination by the Trustees who are unaffiliated with UHS (the Independent Trustees), that the Advisor's performance has been satisfactory. In December of 2009, based upon a review of our advisory fee and other general and administrative expenses, as compared to an industry peer group, the Advisory Agreement was renewed for 2010 and the fee was increased to 0.65% (from 0.60%) of our average invested real estate assets, as derived from our consolidated balance sheet.

The average real estate assets for advisory fee calculation purposes exclude certain items from our consolidated balance sheet such as, among other things, accumulated depreciation, cash and cash equivalents, base and bonus rent receivables, deferred charges and other assets. The advisory fee is payable quarterly, subject to adjustment at year-end based upon our audited financial statements. In addition, the Advisor is entitled to an annual incentive fee equal to 20% of the amount by which cash available for distribution to shareholders for each year, as defined in the Advisory Agreement, exceeds 15% of our equity as shown on our consolidated balance sheet, determined in accordance with generally accepted accounting principles without reduction for return of capital dividends. The Advisory Agreement defines cash available for distribution to shareholders as net cash flow from operations less deductions for, among other things, amounts required to discharge our debt and liabilities and reserves for replacement and capital improvements to our properties and investments. No incentive fees were paid during 2009, 2008 or 2007 since the incentive fee requirements were not achieved. Advisory fees incurred and paid (or payable) to UHS amounted to \$1.6 million during each of 2009 and 2008 and \$1.4 million for 2007 and were based upon average invested real estate assets of \$268 million, \$261 million and \$237 million during 2009, 2008 and 2007, respectively. Based upon our average invested real estate assets of \$268 million during 2009, the increase in the advisory fee expense to 0.65% (beginning in 2010) from 0.60%, amounts to \$134,000 annually.

Officers and Employees: Our officers are all employees of UHS and although as of December 31, 2009 we had no salaried employees, our officers do receive stock-based compensation.

Share Ownership: As of December 31, 2009 and 2008, UHS owned 6.5% and 6.6% of our outstanding shares of beneficial interest, respectively.

UHS Other Matters:

Southwest Healthcare System: UHS has advised us that, during the third quarter of 2009, Southwest Healthcare System (SWHCS), a wholly-owned subsidiary of UHS which operates Rancho Springs Medical Center (the real property of which is not owned by us) and Inland Valley Regional Medical Center (Inland Valley, the real property of which is owned by us) in Riverside County, California, entered into an agreement with the Center for Medicare and Medicaid Services (CMS). The agreement required SWHCS to engage an independent quality monitor to assist SWHCS in meeting all CMS conditions of participation. Further, the agreement provided that during the last 60 days of the agreement CMS would conduct a full Medicare certification survey. That survey took place the week of January 11, 2010. At present, UHS has not been advised

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of the results by CMS. While UHS has advised us that it believes that SWHCS has complied with all obligations under the agreement, there can be no assurance as to the outcome of such a survey or that the outcome would not have a material adverse effect on UHS. While the base rentals on Inland Valley are guaranteed by UHS through the end of the existing lease term (December, 2011), should this matter adversely impact the future revenues and/or operating results of SWHCS, the future bonus rental earned by us on Inland Valley, and the underlying value of the property, may be materially adversely impacted. Bonus rental revenue earned by us from Inland Valley amounted to \$1.1 million, \$1.0 million and \$900,000 during the years ended December 31, 2009, 2008 and 2007, respectively.

South Texas Health System affiliates: UHS, together with its South Texas Health System affiliates, which operate McAllen Medical Center, were served with a subpoena dated November 21, 2005, issued by the Office of Inspector General of the Department of Health and Human Services (OIG). At that time, the Civil Division of the U.S. Attorney's office in Houston, Texas indicated that the subpoena was part of an investigation under the False Claims Act regarding compliance with Medicare and Medicaid rules and regulations pertaining to the payments to physicians and the solicitation of patient referrals from physicians from January 1, 1999 to the date of the subpoena, related to the South Texas Health System. The Civil Division of the U.S. Attorney's office in Houston, Texas focused on certain arrangements entered into by the South Texas Health System affiliates which, the government believes, may have violated Medicare and Medicaid rules and regulations pertaining to payments to physicians and the solicitation of patient referrals from physicians and other matters relating to payments to various individuals which may have constituted improper payments. UHS cooperated with the investigations and during the fourth quarter of 2009, reached an agreement to resolve the matter. UHS agreed to make a payment in the amount of \$27.5 million, which was paid in October, 2009, and has entered into a five-year corporate integrity agreement with respect to the South Texas Health Systems facilities. UHS does not expect to incur additional material charges with respect to this matter.

Taxation

We believe we have operated in such a manner as to qualify for taxation as a REIT under Sections 856 through 860 of the Internal Revenue Code of 1986, as amended, and we intend to continue to operate in such a manner. If we qualify for taxation as a REIT, we will generally not be subject to federal corporate income taxes on our net income that is currently distributed to shareholders. This treatment substantially eliminates the double taxation, e.g. at the corporate and shareholder levels, that usually results from investment in the stock of a corporation. Please see the heading *If we fail to maintain our REIT status, we will become subject to federal income tax on our taxable income at regular corporate rates* under Risk Factors for more information.

Competition

We compete for the acquisition, leasing and financing of health care related facilities. Our competitors include, but are not limited to, other REITs, banks and other companies, including UHS. Some of these competitors are larger and may have a lower cost of capital than we do. These developments could result in fewer investment opportunities for us and lower spreads over the cost of our capital, which would hurt our growth.

In most geographical areas in which our facilities operate, there are other facilities that provide services comparable to those offered by our facilities. In addition, some competing facilities are owned by tax-supported governmental agencies or by nonprofit corporations and may be supported by endowments and charitable contributions and exempt from property, sales and income taxes. Such exemptions and support are not available to our facilities. In some markets, certain competing facilities may have greater financial resources, be better equipped and offer a broader range of services than those available at our facilities. Certain hospitals that are located in the areas served by our facilities are specialty hospitals that provide medical, surgical and behavioral health services, facilities and equipment that are not available at our hospitals. The increase in outpatient treatment and diagnostic facilities, outpatient surgical centers and freestanding ambulatory surgical centers also increases competition for us.

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In addition, the number and quality of the physicians on a hospital's staff are important factors in determining a hospital's success and competitive advantage. Typically, physicians are responsible for making hospital admissions decisions and for directing the course of patient treatment. The operators of our facilities also compete with other health care providers in recruiting and retaining qualified hospital management, nurses and other medical personnel. From time-to-time, the operators of our acute care and behavioral health care facilities may experience the effects of a shortage of skilled nursing staff nationwide, which has caused and may continue to cause an increase in salaries, wages and benefits expense in excess of the inflation rate. Our operators may experience difficulties attracting and retaining qualified physicians, nurses and medical support personnel. We anticipate that our operators, including UHS, will continue to encounter increased competition in the future that could lead to a decline in patient volumes and harm their businesses, which in turn, could harm our business.

A large portion of our non-hospital properties consist of MOB's which are located either close to or on the campuses of hospital facilities. These properties are either directly or indirectly affected by the factors discussed above as well as general real estate factors such as the supply and demand of office space and market rental rates. To improve our competitive position, we anticipate that we will continue investing in additional healthcare related facilities and leasing the facilities to qualified operators, perhaps including UHS and subsidiaries of UHS.

Regulation and Other Factors

During 2009, 2008 and 2007, 48%, 51% and 53%, respectively, of our revenues were earned pursuant to leases with operators of acute care services hospitals, all of which are subsidiaries of UHS. A significant portion of the revenue earned by the operators of our acute care hospitals is derived from federal and state healthcare programs, including Medicare and Medicaid (excluding managed Medicare and Medicaid programs).

The healthcare industry is subject to numerous laws, regulations and rules including, among others, those related to government healthcare participation requirements, various licensure and accreditations, reimbursement for patient services, health information privacy and security rules, and Medicare and Medicaid fraud and abuse provisions (including, but not limited to, federal statutes and regulations prohibiting kickbacks and other illegal inducements to potential referral sources, false claims submitted to federal health care programs and self-referrals by physicians). Providers that are found to have violated any of these laws and regulations may be excluded from participating in government healthcare programs, subjected to significant fines or penalties and/or required to repay amounts received from the government for previously billed patient services. This government regulation of the healthcare industry affects us because:

- (i) The financial ability of lessees to make rent payments to us may be affected by governmental regulations such as licensure, certification for participation in government programs, and government reimbursement, and;
- (ii) Our bonus rents are based on our lessees' net revenues which in turn are affected by the amount of reimbursement such lessees receive from the government.

Although UHS and the other operators of our acute care facilities believe that their policies, procedures and practices comply with governmental regulations, no assurance can be given that they will not be subjected to additional governmental inquiries or actions, or that they would not be faced with sanctions, fines or penalties if so subjected. Even if they were to ultimately prevail, a significant governmental inquiry or action under one of the above laws, regulations or rules could have a material adverse effect upon them, and in turn, us. See *Relationship with Universal Health Services, Inc.-UHS Other Matters* for disclosure related to Southwest Healthcare System.

A significant portion of the revenue earned by the operators of our acute care hospitals is derived from federal and state healthcare programs, including Medicare and Medicaid. Under the statutory framework of the Medicare and Medicaid programs, many of the general acute care

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operations are subject to administrative rulings, interpretations and discretion that may affect payments made under either or both of such programs as well as by other third party payors. The federal government makes payments to participating hospitals under its

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Medicare program based on various formulas. For inpatient services, the operators of our acute care hospitals are subject to a inpatient prospective payment system (IPPS). Under IPPS, hospitals are paid a predetermined fixed payment amount for each hospital discharge. The fixed payment amount is based upon each patient s Medicare severity diagnosis related group (MS-DRG). Every MS-DRG is assigned a payment rate based upon the estimated intensity of hospital resources necessary to treat the average patient with that particular diagnosis. These rates are based upon historical national average costs and do not consider the actual costs incurred by a hospital in providing care. The MS-DRG rates are adjusted annually based on geographic region and are weighted based upon a statistically normal distribution of severity.

For outpatient services, both general acute and behavioral health hospitals are paid under an outpatient PPS according to ambulatory procedure codes. Outpatient services were traditionally paid at the lower of customary charges or on a reasonable cost basis. The outpatient PPS rate is an unadjusted national payment amount that includes the Medicare payment and the beneficiary co-payment. Special payments under the outpatient PPS may be made for certain new technology items and services through transitional pass-through payments and special reimbursement rates.

Given the increasing budget deficits, the federal government and many states are currently considering additional ways to limit increases in levels of Medicare and Medicaid funding, which could also adversely affect future payments received by operators of our facilities. In addition to statutory and regulatory changes to Medicare and each of the state Medicaid programs, our operators operations and reimbursement may be affected by administrative rulings, new or novel interpretations and determinations of existing laws and regulations, post-payment audits, requirements for utilization review and new governmental funding restrictions, all of which may materially increase or decrease program payments as well as affect the cost of providing services and the timing of payments to our facilities.

Healthcare reform proposals are being formulated by the legislative and executive branches of the federal government. In addition, some of the states in which our operators operate periodically consider various healthcare reform proposals. We anticipate that the debate of alternative healthcare delivery systems and payment methodologies will continue and may be enacted in the future. Due to uncertainties regarding the ultimate features of these programs and whether or when they may be enacted, the operators of our facilities cannot predict what effect they will have on them or whether they will adversely affect their results of operations or financial condition and, thus, our business.

We cannot predict whether any proposals will be adopted or, if adopted, what effect, if any, these proposals would have on operators and, thus, our business.

Executive Officers of the Registrant

Name	Age	Position
Alan B. Miller	72	Chairman of the Board, Chief Executive Officer and President
Charles F. Boyle	50	Vice President and Chief Financial Officer
Cheryl K. Ramagano	47	Vice President, Treasurer and Secretary
Timothy J. Fowler	54	Vice President, Acquisition and Development

Mr. Alan B. Miller has been our Chairman of the Board and Chief Executive Officer since our inception in 1986 and was appointed President in February of 2003. He had previously served as our President until 1990. Mr. Miller has been Chairman of the Board and Chief Executive Officer of UHS since its inception in 1978. He previously held the title of President of UHS as well, until 2009 when Marc D. Miller was elected as President of UHS. Mr. Miller also serves as a Director of Penn Mutual Life Insurance Company. He is the father of Marc D. Miller, who was elected to our Board of Trustees in December, 2008 and also serves as President and a member of the Board of Directors of UHS.

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Mr. Charles F. Boyle was appointed Chief Financial Officer in February of 2003 and had served as our Vice President and Controller since 1991. Mr. Boyle has held various positions at UHS since 1983 and currently serves as its Vice President and Controller. He was appointed Controller of UHS in 2003 and had served as its Assistant Vice President-Corporate Accounting since 1994.

Ms. Cheryl K. Ramagano was appointed Secretary in February of 2003 and served as our Vice President and Treasurer since 1992. Ms. Ramagano has held various positions at UHS since 1983 and currently serves as its Vice President and Treasurer. She was appointed Treasurer of UHS in 2003 and had served as its Assistant Treasurer since 1994.

Mr. Timothy J. Fowler was elected as our Vice President of Acquisition and Development upon the commencement of his employment with UHS in 1993.

ITEM 1A. Risk Factors

We are subject to numerous known and unknown risks, many of which are described below and elsewhere in this Annual Report. Any of the events described below could have a material adverse effect on our business, financial condition and results of operations. Additional risks and uncertainties that we are not aware of, or that we currently deem to be immaterial, could also impact our business and results of operations.

General economic and employment conditions in the United States could materially affect the business and future results of operations of the operators of our facilities which could, in turn, materially reduce our revenues and net income.

Our future results of operations could be unfavorably impacted by continued deterioration in general economic conditions which could result in increases in the number of people unemployed and/or uninsured. Should that occur, it may result in decreased occupancy rates at our medical office buildings as well as a reduction in the revenues earned by the operators of our hospital facilities which would unfavorably impact our future bonus rentals (on the UHS hospital facilities) and may potentially have a negative impact on the future lease renewal terms and the underlying value of the hospital properties. Additionally, the general real estate market has been unfavorably impacted by the deterioration in economic and credit market conditions which may adversely impact the underlying value of our properties.

The revenues and results of operations of the tenants of our hospital facilities, including UHS, and our medical office buildings, are significantly affected by payments received from the government and other third party payors.

The operators of our hospital facilities and tenants of our medical office buildings derive a significant portion of their revenue from third party payors, including the Medicare and Medicaid programs. Changes in these government programs in recent years have resulted in limitations on reimbursement and, in some cases, reduced levels of reimbursement for health care services. Payments from federal and state government programs are subject to statutory and regulatory changes, administrative rulings, interpretations and determinations, requirements for utilization review, and federal and state funding restrictions, all of which could materially increase or decrease program payments, as well as affect the cost of providing service to patients and the timing of payments to facilities. Our tenants are unable to predict the effect of future policy changes on their operations. In addition, the uncertainty and fiscal pressures placed upon federal and state governments as a result of, among other things, the substantial deterioration in general economic conditions, the funding requirements from the federal government's stimulus package, the War on Terrorism and the relief efforts related to hurricanes and other disasters, may affect the availability of taxpayer funds for Medicare and Medicaid programs. If the rates paid or the scope of services covered by government payors are reduced, there could be a material adverse effect on our tenants' business, financial position and results of operations, and in turn, ours.

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In addition to changes in government reimbursement programs, the ability of our hospital operators to negotiate favorable contracts with private payors, including managed care providers, significantly affects the revenues and operating results of those facilities. Private payors, including managed care providers, increasingly are demanding that hospitals accept lower rates of payment. Our hospital operators expect continued third party efforts to aggressively manage reimbursement levels and cost controls. Reductions in reimbursement amounts received from third party payors could have a material adverse effect on the financial position and results of operations of our hospital operators.

The uncertainties of health care reform could materially affect the business and future results of operations of the operators of our facilities, including UHS, which could, in turn, materially reduce our revenues and net income.

An increasing number of legislative initiatives have been introduced or proposed in recent years that would result in major changes in the health care delivery system on a national or a state level. Among the proposals that have been introduced are price controls on hospitals, insurance market reforms to increase the availability of group health insurance to small businesses, requirements that all businesses offer health insurance coverage to their employees and the creation of government health insurance plans that would cover all citizens and increase payments by beneficiaries. The operators of our facilities, including UHS, cannot predict whether any of the above proposals or other proposals will be adopted and, if adopted, no assurances can be given that their implementation will not have a material adverse effect on the businesses, financial condition and/or results of operations of our tenants.

Increased competition in the health care industry has resulted in lower revenues and higher costs for our operators, including UHS, and may affect our revenues, property values and lease renewal terms.

The health care industry is highly competitive and competition among hospitals and other health care providers for patients has intensified in recent years. In most geographical areas in which our facilities are operated, there are other facilities that provide services comparable to those offered by our facilities. In addition, some competing facilities are owned by tax-supported governmental agencies or by nonprofit corporations and may be supported by endowments and charitable contributions and exempt from property, sale and income taxes. Such exemptions and support are not available to our operators. In some markets, certain competing facilities may have greater financial resources, be better equipped and offer a broader range of services than those available at our facilities. Certain hospitals that are located in the areas served by our operators facilities are specialty or large hospitals that provide medical, surgical and behavioral health services, facilities and equipment that are not available at our operators hospitals. The increase in outpatient treatment and diagnostic facilities, outpatient surgical centers and freestanding ambulatory surgical centers also increases competition for our operators.

In addition, the number and quality of the physicians on a hospital's staff are important factors in determining a hospital's competitive advantage. Typically, physicians are responsible for making hospital admissions decisions and for directing the course of patient treatment. The operators of our facilities also compete with other health care providers in recruiting and retaining qualified hospital management, nurses and other medical personnel. The operators of our acute care and behavioral health care facilities are experiencing the effects of a shortage of skilled nursing staff nationwide, which has caused and may continue to cause an increase in salaries, wages and benefits expense in excess of the inflation rate. Our operators may experience difficulties attracting and retaining qualified physicians, nurses and medical support personnel. We anticipate that our operators, including UHS, will continue to encounter increased competition in the future that could lead to a decline in patient volumes and harm their businesses, which in turn, could harm our business.

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Operators that fail to comply with governmental reimbursement programs such as Medicare or Medicaid, licensing and certification requirements, fraud and abuse regulations or new legislative developments may be unable to meet their obligations to us.

Our operators, including UHS and its subsidiaries, are subject to numerous federal, state and local laws and regulations that are subject to frequent and substantial changes (sometimes applied retroactively) resulting from legislation, adoption of rules and regulations, and administrative and judicial interpretations of existing law. The ultimate timing or effect of these changes cannot be predicted. Government regulation may have a dramatic effect on our operators' costs of doing business and the amount of reimbursement received by both government and other third-party payors. The failure of any of our operators to comply with these laws, requirements and regulations could adversely affect their ability to meet their obligations to us. These regulations include, among other items: hospital billing practices; relationships with physicians and other referral sources; adequacy of medical care; quality of medical equipment and services; qualifications of medical and support personnel; confidentiality, the implementation of an electronic health records application by 2015; maintenance and security issues associated with health-related information and patient medical records; the screening, stabilization and transfer of patients who have emergency medical conditions; licensure and accreditation of our facilities; hospital rate or budget review; operating policies and procedures, and; construction or expansion of facilities and services.

If our operators fail to comply with applicable laws and regulations, they could be subjected to liabilities, including criminal penalties, civil penalties (including the loss of their licenses to operate one or more facilities), and exclusion of one or more facilities from participation in the Medicare, Medicaid and other federal and state health care programs. The imposition of such penalties could jeopardize that operator's ability to make lease or mortgage payments to us or to continue operating its facility. In addition, our bonus rents are based on our operators' net revenues, which in turn are affected by the amount of reimbursement that such lessees receive from the government.

Although UHS and the other operators of our acute care facilities believe that their policies, procedures and practices comply with governmental regulations, no assurance can be given that they will not be subjected to governmental inquiries or actions, or that they would not be faced with sanctions, fines or penalties if so subjected. Because many of these laws and regulations are relatively new, in many cases, our operators do not have the benefit of regulatory or judicial interpretation. In the future, it is possible that different interpretations or enforcement of these laws and regulations could subject their current or past practices to allegations of impropriety or illegality or could require them to make changes in the facilities, equipment, personnel, services, capital expenditure programs and operating expenses. Even if they were to ultimately prevail, a significant governmental inquiry or action under one of the above laws, regulations or rules could have a material adverse effect upon them, and in turn, us.

UHS's Southwest Healthcare System: UHS has advised us that, during the third quarter of 2009, Southwest Healthcare System (SWHCS), a wholly-owned subsidiary of UHS which operates Rancho Springs Medical Center (the real property of which is not owned by us) and Inland Valley Regional Medical Center (Inland Valley, the real property of which is owned by us) in Riverside County, California, entered into an agreement with the Center for Medicare and Medicaid Services (CMS). The agreement required SWHCS to engage an independent quality monitor to assist SWHCS in meeting all CMS conditions of participation. Further, the agreement provided that during the last 60 days of the agreement CMS would conduct a full Medicare certification survey. That survey took place the week of January 11, 2010. At present, UHS has not been advised of the results from CMS. While UHS has advised us that it believes that SWHCS has complied with all obligations under the agreement, there can be no assurance as to the outcome of such a survey or that the outcome would not have a material adverse effect on UHS. While the base rentals on Inland Valley are guaranteed by UHS through the end of the existing lease term (December, 2011), should this matter adversely impact the future revenues and/or operating results of SWHCS, the future bonus rental earned by us on Inland Valley, and the underlying value of the property, may be materially adversely impacted. Bonus rental revenue

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earned by us from Inland Valley amount to \$1.1 million, \$1.0 million and \$900,000 during the years ended December 31, 2009, 2008 and 2007, respectively.

The deterioration of credit and capital markets may adversely affect our access to sources of funding and we cannot be certain of the availability and terms of capital to fund the growth of our business when needed.

To retain our status as a REIT, we are required to distribute 90% of our taxable income to shareholders and, therefore, we generally cannot use income from operations to fund our growth. Accordingly, our growth strategy depends, in part, upon our ability to raise additional capital at reasonable costs to fund new investments. We believe we will be able to raise additional debt and equity capital at reasonable costs to refinance our debts (including third-party debt held by various LLCs in which we own non-controlling equity interests) at or prior to their maturities and to invest at yields which exceed our cost of capital. Although the ongoing tightening in the credit markets has not had a material impact on us, we can provide no assurance that financing will be available to us on satisfactory terms when needed, which could harm our business. Given these uncertainties, our growth strategy is not assured and may fail.

To fund all or a portion of our future financing needs, we rely on borrowings from various sources including fixed rate, long-term debt as well as borrowings pursuant to our revolving credit agreement. If any of the lenders were unable to fulfill their future commitments, our liquidity could be impacted, which could have a material unfavorable impact our results of operations and financial condition.

In addition, the degree to which we are, or in the future may become, leveraged, our ability to obtain financing could be adversely impacted and could make us more vulnerable to competitive pressures. Our ability to meet existing and future debt obligations, depends upon our future performance and our ability to secure additional financing on satisfactory terms, each of which is subject to financial, business and other factors that are beyond our control. Any failure by us to meet our financial obligations would harm our business.

In addition, global capital markets have experienced volatility that has tightened access to capital markets and other sources of funding. In the event we need to access the capital markets or other sources of financing, there can be no assurance that we will be able to obtain financing on acceptable terms or within an acceptable time. Our inability to obtain financing on terms acceptable to us could have a material unfavorable impact on our results of operations, financial condition and liquidity.

A substantial portion of our revenues are dependent upon one operator. If UHS experiences financial difficulties, or otherwise fails to make payments to us, our revenues will significantly decline.

For the year ended December 31, 2009, UHS accounted for 59% of our consolidated revenues. In addition, as of December 31, 2009, subsidiaries of UHS leased four of the seven hospital facilities owned by us with terms expiring in 2011 or 2014. We cannot assure you that UHS will continue to satisfy its obligations to us. The failure or inability of UHS to satisfy its obligations to us could materially reduce our revenues and net income, which could in turn reduce the amount of dividends we pay and cause our stock price to decline.

Our relationship with UHS may create conflicts of interest.

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In addition to being dependent upon UHS for a substantial portion of our revenues and leases, since 1986, UHS of Delaware, Inc. (the Advisor), a wholly-owned subsidiary of UHS, has served as our Advisor. Pursuant to our Advisory Agreement, the Advisor is obligated to present an investment program to us, to use its best efforts to obtain investments suitable for such program (although it is not obligated to present any particular investment opportunity to us), to provide administrative services to us and to conduct our day-to-day affairs. Further, all of our officers are employees of UHS. As of December 31, 2009, we had no salaried employees although our officers do receive stock-based compensation. We believe that the quality and depth of the management and advisory services provided to us by our Advisor and UHS could not be replicated by

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contracting with unrelated third parties or by being self-advised without considerable cost increases. We believe that these relationships have been beneficial to us in the past, but we cannot guarantee that they will not become detrimental to us in the future.

All transactions with UHS must be approved by a majority of our Independent Trustees. We believe that our current leases and business dealings with UHS have been entered into on commercially reasonable terms. However, because of our historical and continuing relationship with UHS and its subsidiaries, in the future, our business dealings may not be on the same or as favorable terms as we might achieve with a third party with whom we do not have such a relationship. Disputes may arise between us and UHS that we are unable to resolve or the resolution of these disputes may not be as favorable to us as a resolution we might achieve with a third party.

We hold significant, non-controlling equity ownership interests in various LLCs.

For the year ended December 31, 2009, 61% of our consolidated and unconsolidated revenues were generated by LLCs in which we hold a majority, non-controlling equity ownership interest. Our level of investment and lack of control exposes us to potential losses of our investments and revenues. Although our ownership arrangements have been beneficial to us in the past, we cannot guarantee that they will continue to be beneficial in the future.

The bankruptcy, default, insolvency or financial deterioration of our tenants could significantly delay our ability to collect unpaid rents or require us to find new operators.

Our financial position and our ability to make distributions to our shareholders may be adversely affected by financial difficulties experienced by any of our major tenants, including bankruptcy, insolvency or a general downturn in the business. We are exposed to the risk that our operators may not be able to meet their obligations, which may result in their bankruptcy or insolvency. Although our leases and loans provide us the right to terminate an investment, evict an operator, demand immediate repayment and other remedies, the bankruptcy laws afford certain rights to a party that has filed for bankruptcy or reorganization. An operator in bankruptcy may be able to restrict our ability to collect unpaid rents or interest during the bankruptcy proceeding.

Real estate ownership creates risks and liabilities that may result in unanticipated losses or expenses.

Our business is subject to risks associated with real estate acquisitions and ownership, including:

general liability, property and casualty losses, some of which may be uninsured;

the illiquid nature of real estate and the real estate market that impairs our ability to purchase or sell our assets rapidly to respond to changing economic conditions;

real estate market factors, such as the supply and demand of office space and market rental rates, changes in interest rates as well as an increase in the development of medical office condominiums in certain markets;

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costs that may be incurred relating to maintenance and repair, and the need to make expenditures due to changes in governmental regulations, including the Americans with Disabilities Act;

environmental hazards at our properties for which we may be liable, including those created by prior owners or occupants, existing tenants, mortgagors or other persons, and;

defaults and bankruptcies by our tenants.

In addition to the foregoing risks, we cannot predict whether the leases on our properties, including the leases on the properties leased to subsidiaries of UHS, which have options to purchase the respective leased facilities at the end of the lease or renewal terms at the appraised fair market value, will be renewed at their

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current rates at the end of the lease terms in 2011 or 2014. If the leases are not renewed, we may be required to find other operators for these facilities and/or enter into leases with less favorable terms. The exercise of purchase options for our facilities may result in a less favorable rate of return for us than the rental revenue currently earned on such facilities. Further, the purchase options and rights of first refusal granted to the respective lessees to purchase or lease the respective leased facilities, after the expiration of the lease term, may adversely affect our ability to sell or lease a facility, and may present a potential conflict of interest between us and UHS since the price and terms offered by a third-party are likely to be dependent, in part, upon the financial performance of the facility during the final years of the lease term.

Significant potential liabilities and rising insurance costs and availability may have an adverse effect on the operations of our operators, which may negatively impact their ability to meet their obligations to us.

As is typical in the healthcare industry, in the ordinary course of business, our operators, including UHS, are subject to medical malpractice lawsuits, product liability lawsuits and other legal actions. Some of these actions may involve large claims, as well as significant defense costs. If their ultimate liability for professional and general liability claims could change materially from current estimates, if such policy limitations should be partially or fully exhausted in the future, or payments of claims exceed estimates or are not covered by insurance, it could have a material adverse effect on the operations of our operators.

In addition, the malpractice expenses of our operators, including UHS, have increased in recent years which may increase their self-insured exposure for professional and general liability claims. There can be no assurance that insurance will continue to be available at reasonable prices that allow them to maintain adequate coverage. If these trends continue, they could have a material adverse effect on their operations. Property insurance rates, particularly for earthquake insurance in California, have also continued to increase. Three LLCs that own properties in California, in which we have various non-controlling equity interests, could not obtain earthquake insurance at rates which are economically beneficial in relation to the risks covered.

Our tenants and operators, including UHS, may be unable to fulfill their insurance, indemnification and other obligations to us under their leases and mortgages and thereby potentially expose us to those risks. In addition, our tenants and operators may be unable to pay their lease or mortgage payments, which could potentially decrease our revenues and increase our collection and litigation costs. Moreover, to the extent we are required to foreclose on the affected facilities, our revenues from those facilities could be reduced or eliminated for an extended period of time. In addition, we may in some circumstances be named as a defendant in litigation involving the actions of our operators. Although we have no involvement in the activities of our operators and our standard leases generally require our operators to carry insurance to cover us in certain cases, a significant judgment against us in such litigation could exceed our and our operators' insurance coverage, which would require us to make payments to cover the judgment.

If we fail to maintain our REIT status, we will become subject to federal income tax on our taxable income at regular corporate rates.

In order to qualify as a REIT, we must comply with certain highly technical and complex Internal Revenue Code provisions. Although we believe we have been qualified as a REIT since our inception, there can be no assurance that we have been so qualified or will remain qualified in the future. Failure to qualify as a REIT may subject us to income tax liabilities, including federal income tax at regular corporate rates. The additional income tax incurred may significantly reduce the cash flow available for distribution to shareholders and for debt service. In addition, if disqualified, we might be barred from qualification as a REIT for four years following disqualification.

Dividends paid by REITs generally do not qualify for reduced tax rates.

In general, the maximum U.S. federal income tax rate for dividends paid to individual U.S. shareholders is 15% (through 2009). Unlike dividends received from a corporation that is not a REIT, our distributions to individual shareholders generally are not eligible for the reduced rates.

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Should we be unable to comply with the strict income distribution requirements applicable to REITs utilizing only cash generated by operating activities, we would be required to generate cash from other sources which could adversely affect our financial condition.

To obtain the favorable tax treatment associated with qualifying as a REIT, in general, we are required each year to distribute to our shareholders at least 90% of our net taxable income. In addition, we are subject to a tax on any undistributed portion of our income at regular corporate rates and might also be subject to a 4% excise tax on this undistributed income. To meet the distribution requirements necessary to achieve the tax benefits associated with qualifying as a REIT, we could be required to: (i) seek borrowed funds even if conditions are not favorable for borrowing; (ii) issue equity which could have a dilutive effect on the future dividends and share value of our existing shareholders; (iii) divest assets that we might have otherwise decided to retain, and/or; (iv) forgo attractive investment opportunities that we might have otherwise pursued. Securing funds through these other non-operating means could adversely affect our financial condition and future results of operations.

The market value of our common stock could be substantially affected by various factors.

Many factors, certain of which are outside of our control, could have an adverse effect on the share price of our common stock. These factors include certain of the risks discussed herein, our financial condition, performance and prospects, the market for similar securities issued by REITs, demographic changes, operating results of our operators and other hospital companies, changes in our financial estimates or recommendations of securities analysts, speculation in the press or investment community, the possible effects of war, terrorist and other hostilities, adverse weather conditions, the level of seasonal illnesses, changes in general conditions in the economy or the financial markets, or other developments affecting the health care industry.

Ownership limitations and anti-takeover provisions in our declaration of trust and bylaws and under Maryland law and in our Leases with UHS may delay, defer or prevent a change in control or other transactions that could provide shareholders with a take-over premium. We are subject to significant anti-takeover provisions.

In order to protect us against the risk of losing our REIT status for federal income tax purposes, our declaration of trust permits our Trustees to redeem shares acquired or held in excess of 9.8% of the issued and outstanding shares of our voting stock and, which in the opinion of the Trustees would jeopardize our REIT status. In addition, any acquisition of our common or preferred shares that would result in our disqualification as a REIT is null and void. The right of redemption may have the effect of delaying, deferring or preventing a change in control of our company and could adversely affect our shareholders' ability to realize a premium over the market price for the shares of our common stock.

Our declaration of trust authorizes our Board of Trustees to issue additional shares of common and preferred stock and to establish the preferences, rights and other terms of any series of preferred stock that we issue. Although our Board of Trustees has no intention to do so at the present time, it could establish a series of preferred stock that could delay, defer or prevent a transaction or a change in control that might involve the payment of a premium over the market price for our common stock or otherwise be in the best interests of our shareholders.

Pursuant to the Master Lease Document by and among us and certain subsidiaries of UHS, which governs the leases of all hospital properties with subsidiaries of UHS includes a change of control provision. The change of control provision grants UHS the right, upon one month's notice should a change of control of the Trust occur, to purchase any or all of the four leased hospital properties at their appraised fair market values. The exercise of this purchase option may result in a less favorable rate of return than the rental revenue currently earned on such facilities.

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These provisions could discourage unsolicited acquisition proposals or make it more difficult for a third-party to gain control of us, which could adversely affect the market price of our securities and prevent shareholders from receiving a take-over premium.

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We depend heavily on key management personnel and the departure of one or more of our key executives or a significant portion of our operators' local hospital management personnel could harm our business.

The expertise and efforts of our senior executives and key members of our operators' local hospital management personnel are critical to the success of our business. The loss of the services of one or more of our senior executives or of a significant portion of our operators' local hospital management personnel could significantly undermine our management expertise and our operators' ability to provide efficient, quality health care services at our facilities, which could harm their business, and in turn, harm our business.

Increasing investor interest in our sector and consolidation at the operator or REIT level could increase competition and reduce our profitability.

Our business is highly competitive and we expect that it may become more competitive in the future. We compete for the acquisition, leasing and financing of health care related facilities. Our competitors include, but are not limited to, other REITs, banks and other companies, including UHS, some of which are larger and may have a lower cost of capital than we do. These developments could result in fewer investment opportunities for us and lower spreads over our cost of our capital, which would hurt our growth.

We are subject to significant corporate regulation as a public company and failure to comply with all applicable regulations could subject us to liability or negatively affect our stock price.

As a publicly traded company, we are subject to a significant body of regulation, including the Sarbanes-Oxley Act of 2002. While we have developed and instituted a corporate compliance program based on what we believe are the current best practices in corporate governance and continue to update this program in response to newly implemented or changing regulatory requirements, we cannot provide assurance that we are or will be in compliance with all potentially applicable corporate regulations. For example, we cannot provide assurance that in the future our management will not find a material weakness in connection with its annual review of our internal control over financial reporting pursuant to Section 404 of the Sarbanes-Oxley Act. We also cannot provide assurance that we could correct any such weakness to allow our management to assess the effectiveness of our internal control over financial reporting as of the end of our fiscal year in time to enable our independent registered public accounting firm to state that such assessment will have been fairly stated in our Annual Report on Form 10-K or state that we have maintained effective internal control over financial reporting as of the end of our fiscal year. If we fail to comply with any of these regulations, we could be subject to a range of regulatory actions, fines or other sanctions or litigation. If we must disclose any material weakness in our internal control over financial reporting, our stock price could decline.

Different interpretations of accounting principles could have a material adverse effect on our results of operations or financial condition.

Generally accepted accounting principles are complex, continually evolving and may be subject to varied interpretation by us, our independent registered public accounting firm and the SEC. Such varied interpretations could result from differing views related to specific facts and circumstances. Differences in interpretation of generally accepted accounting principles could have a material adverse effect on our financial position or results of operations.

Item 1B. Unresolved Staff Comments

None.

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The following table shows our investments in hospital facilities leased to UHS and other non-related parties. The second table provides information related to various properties in which we have significant investments, and/or which generate a significant portion of our net income, some of which are accounted for by the equity method. The capacity in terms of beds (for the hospital facilities) and the five-year occupancy levels are based on information provided by the lessees.

Hospital Facilities	Type of facility	Number of available beds @ 12/31/09	Average Occupancy(1)					Lease Term	End of initial or renewed term	Renewal term (years)
			2009	2008	2007	2006	2005			
Southwest Healthcare System: Inland Valley Campus(2) Wildomar, California	Acute Care	122	77%	77%	67%	85%	87%	\$2,648,000	2011	20
McAllen Medical Center(3) McAllen, Texas	Acute Care	368	43%	50%	51%	52%	59%	5,485,000	2011	20
Wellington Regional Medical Center West Palm Beach, Florida	Acute Care	158	71%	74%	78%	77%	73%	3,030,000	2011	20
The Bridgeway North Little Rock, Arkansas	Behavioral Health	114	79%	83%	94%	92%	96%	930,000	2014	10
HealthSouth Deaconess Rehabilitation Hospital Evansville, Indiana	Rehabilitation	80	60%	55%	57%	53%	74%	885,000	2014	10
Kindred Hospital Corpus Christi Corpus Christi, Texas	Sub-Acute Care	74	61%	63%				667,000	2019	25
Kindred Hospital Chicago Central Chicago, Illinois	Sub-Acute Care	84	45%	44%	38%	46%	47%	1,399,000	2011	15

Other Significant Investments

Other Significant Investments	Type of facility	Average Occupancy(1)					Lease Term	End of initial or renewed term(4)	Renewal term (years)
		2009	2008	2007	2006	2005			
Desert Springs Medical Plaza(4) Las Vegas, Nevada	MOB	74%	78%	77%	96%	100%	\$ 801,000	2010-2025	Various
Deer Valley Medical Office I Phoenix, Arizona	MOB	100%	100%	100%	100%	100%	2,043,000	2010-2017	Various

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Deer Valley Medical Office II(5) Phoenix, Arizona	MOB	53%					1,266,000	2019- 2024	Various
Spring Valley MOB I(4) Las Vegas, Nevada	MOB	96%	96%	95%	91%	82%	751,000	2010- 2018	Various
Spring Valley MOB II(4) Las Vegas, Nevada	MOB	51%	50%	50%			679,000	2014- 2018	Various
Summerlin Hospital MOB I(4) Las Vegas, Nevada	MOB	95%	98%	98%	98%	100%	1,109,000	2010- 2014	Various
Summerlin Hospital MOB II(4) Las Vegas, Nevada	MOB	100%	100%	100%	100%	100%	1,594,000	2010- 2014	Various
Summerlin Hospital MOBIII(4,6) Las Vegas, Nevada	MOB	63%					1,234,000	2014- 2019	Various
Sheffield Medical Building Atlanta, Georgia	MOB	73%	77%	82%	86%	85%	1,138,000	2010- 2019	Various
St. Mary s Professional Office Building Reno, Nevada	MOB	99%	97%	95%	92%	77%	3,985,000	2012- 2025	Various

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- (1) Average occupancy rate for the hospital facilities is based on the average number of available beds occupied during each of the five years ended December 31, 2009. Average available beds is the number of beds which are actually in service at any given time for immediate patient use with the necessary equipment and staff available for patient care. A hospital may have appropriate licenses for more beds than are in service for a number of reasons, including lack of demand, incomplete construction and anticipation of future needs. The average occupancy rate of a hospital is affected by a number of factors, including the number of physicians using the hospital, changes in the number of beds, the composition and size of the population of the community in which the hospital is located, general and local economic conditions, variations in local medical and surgical practices and the degree of outpatient use of the hospital services. Average occupancy rate for the multi-tenant medical office buildings is based on the occupied square footage of each building, including any applicable master leases.
- (2) In July, 2002, the operations of Inland Valley Regional Medical Center (Inland Valley) were merged with the operations of Rancho Springs Medical Center (Rancho Springs), an acute care hospital located in California and also operated by UHS, the real estate assets of which are not owned by us. Inland Valley, our lessee, was merged into Universal Health Services of Rancho Springs, Inc. The merged entity is now doing business as Southwest Healthcare System (Southwest Healthcare). As a result of merging the operations of the two facilities, the revenues of Southwest Healthcare include the revenues of both Inland Valley and Rancho Springs. Although we do not own the real estate assets of the Rancho Springs facility, Southwest Healthcare became the lessee on the lease relating to the real estate assets of the Inland Valley facility. Since the bonus rent calculation for the Inland Valley campus is based on net revenues and the financial results of the two facilities are no longer separable, the lease was amended during 2002 to exclude from the bonus rent calculation the estimated net revenues generated at the Rancho Springs campus (as calculated pursuant to a percentage based allocation determined at the time of the merger). The average occupancy rates shown for this facility for all years were based on the combined number of beds occupied at the Inland Valley and Rancho Springs campuses.
- (3) During the first quarter of 2001, UHS purchased the assets and operations of the 60-bed McAllen Heart Hospital located in McAllen, Texas. Upon the acquisition by UHS, the Heart Hospital began operating under the same license as an integrated department of McAllen Medical Center. As a result of combining the operations of the two facilities, the revenues of McAllen Medical Center include revenues generated by the Heart Hospital, the real property of which is not owned by us. Accordingly, since the bonus rent calculation for McAllen Medical Center is based on the combined net revenues of the two facilities, the McAllen Medical Center lease was amended during 2001 to exclude the net revenues of McAllen Heart Hospital from the bonus rent calculation. In addition, during 2000, UHS purchased the South Texas Behavioral Health Center, a behavioral health care facility located in McAllen, Texas. In 2006, a newly constructed replacement facility for the South Texas Behavioral Health Center was completed and opened. The license for this facility, the real property of which is not owned by us, was also merged with the license for McAllen Medical Center. There was no amendment to the McAllen Medical Center lease related to the operations of the South Texas Behavioral Health Center. The revenues of South Texas Behavioral Health Center are excluded from the bonus rent calculation. No assurance can be given as to the effect, if any, the consolidation of the facilities as mentioned above, had on the underlying value of McAllen Medical Center. Base rental commitments and the guarantee by UHS under the original lease continue for the remainder of the lease terms. The average occupancy rate shown for this facility for 2009 was based upon the combined number of beds and McAllen Medical Center and McAllen Heart Hospital. The average occupancy rates shown for this facility in all other years presented were based on the combined number of beds at McAllen Medical Center, McAllen Heart Hospital and South Texas Behavioral Health Center.
- (4) The real estate assets of this facility are owned by a LLC in which we own a non-controlling equity interest and include tenants who are unaffiliated third-parties or subsidiaries of UHS.
- (5) This MOB was completed and opened during the second quarter of 2009 and the occupancy shown is the average since the opening date.
- (6) This MOB was completed and opened during the first quarter of 2009 and the occupancy shown is the average since the opening date.

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Set forth is information detailing the rentable square feet (RSF) associated with each of our investments and the percentage of RSF on which leases expire during the next five years and thereafter:

	Total RSF	Available for Lease		Percentage of RSF with lease expirations					2015 and Later
		Jan. 1, 2010	2010	2011	2012	2013	2014		
Hospital Investments									
McAllen Medical Center	422,276	0%	0%	100%	0%	0%	0%	0%	0%
Wellington Regional Medical Center	196,489	0%	0%	100%	0%	0%	0%	0%	0%
Southwest Healthcare System Inland Valley Campus	124,644	0%	0%	100%	0%	0%	0%	0%	0%
Kindred Hospital Chicago Central	115,554	0%	0%	100%	0%	0%	0%	0%	0%
The Bridgeway	77,901	0%	0%	0%	0%	0%	100%	0%	0%
HealthSouth Deaconess Rehab. Hospital	77,440	0%	0%	0%	0%	0%	100%	0%	0%
Kindred Hospital, Corpus Christi	69,700	0%	0%	0%	0%	0%	0%	0%	100%
Subtotal Hospitals	1,084,004	0%	0%	79%	0%	0%	14%	7%	
Other Investments									
Medical Office Buildings:									
Desert Samaritan Hospital MOB's	201,108	19%	17%	19%	13%	8%	9%	15%	
Saint Mary's Professional Office Building	190,247	1%	0%	0%	2%	0%	0%	97%	
Edwards Medical Plaza	141,945	17%	18%	2%	29%	14%	7%	13%	
700 Shadow Lane and Goldring MOB's	116,834	18%	29%	5%	19%	16%	3%	10%	
Centinela Medical Buildings	103,353	22%	24%	18%	6%	7%	19%	4%	
Suburban Medical Plaza II	102,818	2%	0%	32%	4%	2%	21%	39%	
Desert Springs Medical Plaza	102,128	29%	29%	8%	18%	5%	0%	11%	
Centennial Hills Medical Office Building I	96,732	32%	0%	0%	5%	20%	20%	23%	
Thunderbird Paseo Medical Plaza I & II	96,569	3%	15%	14%	27%	24%	5%	12%	
Summerlin Hospital Medical Office Building II(c)	92,313	0%	19%	28%	34%	14%	5%	0%	
Canyon Springs Medical Plaza	91,957	8%	0%	0%	14%	0%	2%	76%	
Summerlin Hospital Medical Office Building I	89,636	8%	40%	16%	15%	11%	10%	0%	
Vista Medical Terrace & The Sparks Medical Building	86,378	31%	19%	7%	25%	0%	2%	16%	
Papago Medical Park	79,607	13%	36%	2%	5%	22%	9%	13%	
Summerlin Hospital Medical Office Building III(d)	77,653	37%	0%	0%	0%	0%	37%	26%	
Deer Valley Medical Office II	77,264	0%	10%	0%	61%	6%	0%	23%	
Deer Valley Medical Office III	76,921	31%	0%	0%	0%	0%	0%	69%	
Mid Coast Hospital MOB	74,629	0%	0%	16%	0%	12%	0%	72%	
Sheffield Medical Building	71,940	34%	16%	10%	29%	6%	0%	5%	
Rosenberg Children's Medical Plaza	66,231	0%	10%	7%	7%	51%	0%	25%	
Sierra San Antonio Medical Plaza	59,160	32%	0%	18%	0%	12%	4%	34%	
Palmdale Medical Plaza(a)	58,150	25%	0%	0%	0%	59%	16%	0%	
Spring Valley Medical Office Building	57,828	7%	33%	11%	30%	11%	5%	3%	
Spring Valley Medical Office Building II	57,556	47%	0%	0%	0%	0%	10%	43%	
Southern Crescent Center II(b)	53,680	6%	76%	0%	8%	0%	0%	10%	
Desert Valley Medical Center	53,625	10%	28%	30%	15%	6%	5%	6%	
Auburn Center II	42,408	25%	0%	0%	0%	0%	75%	0%	
Southern Crescent Center I	41,400	52%	4%	0%	22%	0%	22%	0%	
Cypresswood Professional Center	40,082	13%	0%	0%	17%	0%	12%	58%	
Medical Center of Western Connecticut	36,341	0%	11%	0%	0%	5%	17%	67%	
Phoenix Children's East Valley Care Center	30,960	0%	0%	0%	0%	0%	0%	100%	
Apache Junction Medical Plaza	26,901	13%	9%	9%	13%	34%	0%	22%	
Santa Fe Professional Plaza	25,300	39%	11%	5%	27%	12%	0%	6%	
Professional Bldg at King's Crossing	24,414	43%	0%	20%	6%	0%	0%	31%	
Cobre Valley Medical Plaza	21,882	0%	15%	5%	63%	17%	0%	0%	
Kelsey-Seybold Clinic at King's Crossing	20,470	0%	100%	0%	0%	0%	0%	0%	
Orthopaedic Specialists of Nevada Building	11,000	0%	100%	0%	0%	0%	0%	0%	
Family Doctor's MOB	9,155	0%	0%	100%	0%	0%	0%	0%	
Preschool and Childcare Centers:									
Chesterbrook Academy Audubon	8,300	0%	0%	0%	0%	0%	0%	100%	
Chesterbrook Academy Uwchlan	8,163	0%	0%	0%	0%	0%	0%	100%	

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Chesterbrook Academy Newtown	8,100	0%	0%	0%	0%	0%	0%	100%
Chesterbrook Academy New Britain	7,998	0%	0%	0%	0%	0%	0%	100%
Sub-total Other Investments	2,739,136	16%	15%	9%	14%	10%	8%	28%
Total	3,823,140	11%	11%	29%	10%	7%	10%	22%

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- (a) The Palmdale Medical Plaza has a 75% master lease commitment from UHS that expires at the earlier of the commitment threshold being met or the scheduled expiration in June, 2013.
- (b) The Southern Crescent Center II has a master lease agreement that is applicable to 76% of the building that is scheduled to expire in June, 2010.
- (c) The Summerlin Hospital Medical Office Building II has a master lease provision that expires on September 30, 2010 which covers all vacancies.
- (d) The Summerlin Hospital Medical Office Building III has a 25% flex lease commitment as well as a 50% master lease on the remaining 75% of the building (representing 37.5% of the building) from UHS that expires at the earlier of the commitment threshold being met or the scheduled expiration in February, 2014.

The average effective annual rental per square foot for our hospital properties was \$17.81 during 2009 as compared to \$17.54 during 2008, based upon consolidated revenues and total square footage for the hospital facilities. The average effective annual rental per square foot related to our MOBs and childcare centers was \$26.92 during 2009 as compared to \$25.77 during 2008, based upon the consolidated and unconsolidated revenues and the estimated average occupied square footage for all of our MOBs and childcare centers. On a combined basis, based upon all consolidated and unconsolidated revenues and estimated average occupied square footage, the average effective annual rental per square foot for our properties on a portfolio basis was \$24.01 during 2009 as compared to \$23.07 during 2008. The estimated average occupied square footage for 2009 was calculated by averaging the unavailable rentable square footage on January 1, 2009 and January 1, 2010. The estimated average occupied square footage for 2008 was calculated by averaging the unavailable rentable square footage on January 1, 2008 and January 1, 2009.

During 2009, each of three UHS-related hospitals (McAllen Medical Center, Wellington Regional Medical Center and Southwest Healthcare System-Inland Valley Campus) generated revenues that comprised more than 10% of our consolidated revenues. As of December 31, 2009, McAllen Medical Center and Wellington Regional Medical Center had book values of approximately 10% or greater of our total assets. Including 100% of the revenues generated at the properties owned by our unconsolidated LLCs, none of our unconsolidated LLCs had revenues greater than 10% of the combined consolidated and unconsolidated revenues during 2009. Including 100% of the book values of the properties owned by our unconsolidated LLCs, none of the properties had book values greater than 10% of the consolidated and unconsolidated assets.

The following table sets forth the average effective annual rental per square foot for 2009, based upon average occupied square feet for McAllen Medical Center, Wellington Regional Medical Center and Southwest Healthcare System-Inland Valley Campus:

Prope